

Food and Drug Administration  
Center for Food Safety and Applied Nutrition  
Office of Special Nutritionals

ARMS#

12506



8 - OTHER

**000001**

FAX

AUTOPSY REPORT

August 19, 1997

ON THE BODY OF

Address unknown

CAUSE OF DEATH: Cardiomyopathy.

MANNER OF DEATH: Natural.

Assistant Medical Examiner

Date

9-16-97

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POSTMORTEM EXAMINATION ON THE BODY OF

Address unknown

HISTORY: This 32 year old, Caucasian female was transported to [REDACTED] and was pronounced dead on arrival at 8:07 a.m., on August 19, 1997.

AUTOPSY: The autopsy was performed in the [REDACTED] of [REDACTED] by Assistant Medical Examiner [REDACTED] M.D., at the request and upon the written authorization of The Honorable [REDACTED], Justice of the Peace, [REDACTED] beginning at 11:55 a.m., on August 19, 1997.

EXTERNAL APPEARANCE: The body was that of an adult, well developed, well nourished, Caucasian female appearing the stated age of 32 years, measuring 67 inches in length and weighing 137 pounds. There was generalized body rigidity. There was unfixed posterior lividity. The head was covered with light brown hair measuring 11 inches in length at the top of the head. The eyes were green with round and equal pupils. The pupils were dilated bilaterally. The nose and earlobes were unremarkable. Both earlobes were pierced twice. The mouth showed natural teeth in good condition. The oral mucosa was intact. The neck was symmetrical with no masses palpable. The lateral neck veins were distended. The chest was symmetrical. The breasts were unremarkable. The abdomen was flat. The pubic hair was light brown and feminine in distribution. The external genitalia were intact and unremarkable. The lower extremities were symmetrical. The toenails were covered with dark red nail polish. There was a hospital-type band around the left ankle. The upper extremities were symmetrical. There was a recent needle puncture mark in each antecubital fossa. The fingernails were covered with dark red nail polish. There were no needle track scars. The back was intact.

INTERNAL EXAMINATION: Section: The chest and abdomen were opened by the usual Y-shaped thoracoabdominal incision. The chest plate was removed. The subcutaneous adipose tissue at the level of the umbilicus measured 1-1/2 inches in thickness. The peritoneal cavity did not show any abnormal collections of fluid. The lining surfaces were smooth and glistening. The appendix was present and was unremarkable. The pectoral muscles were beefy red. The breasts, on sectioning, were unremarkable. The rib cage was intact. The pericardial and pleural cavities did not show any abnormal collections of fluid. The lining surfaces were smooth and glistening. Both leaves of the diaphragm were intact. The viscera were in their normal anatomic positions and relationships.

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**HEART:** The heart weighed 500 grams with moderate amounts of epicardial adipose tissue. The epicardial surface was smooth and glistening and there were scattered petechiae anteriorly and on the diaphragmatic aspect. There was marked prominence of the left ventricle. The right coronary artery was of relative small size and was smooth, patent, and pliable. The left coronary artery and its branches were smooth, patent, and pliable. The cardiac valve leaflets and cusps were unremarkable. The right ventricle was of average normal thickness. The left ventricle showed marked hypertrophy, concentric in the mid and distal portions and asymmetrical in the proximal portion, with marked hypertrophy of the anterior part of the interventricular septum and also of the anterior left ventricular wall in the subaortic area where the combined septal and ventricular wall measured 2 inches in thickness. The left ventricle, in the mid distal portion, measured 1-1/4 inches in thickness and the septum, in its midportion, measured up to 1 inch in thickness. In the distal portion, the left ventricle averaged 3/4 inch in thickness. The myocardium was of firm consistency and the fibers grossly also had a partially whorled appearance and there were intermixed areas of fibrosis in the most thickened parts. The interatrial septum was intact. The aorta and its major branches were intact and showed no significant arteriosclerosis.

**LUNGS:** The right lung weighed 525 grams and the left lung weighed 600 grams. The lungs were purple and were of marked soggy consistency. The pleural surfaces were smooth and glistening and showed mild anthracotic mottling. The pulmonary artery branches did not show any thromboemboli. The tracheobronchial tree was lined by intact mucosa and contained abundant edema fluid. The lungs on sectioning did not show any tumor or consolidation. The cut surfaces exuded abundant fluid material.

**LIVER:** The liver weighed 1750 grams. The capsule was intact. The external and cut surfaces were uniformly brown with no focal lesions. The gallbladder contained approximately 40 milliliters of bile and no gallstones.

**Pancreas:** The pancreas weighed approximately 125 grams and was of normal configuration. On sectioning, it revealed a pale tan lobulated parenchyma with no focal lesions.

**Adrenals:** Both adrenals were unremarkable on the external and cut surfaces.

**SPLEEN:** The spleen weighed 200 grams with an intact capsule. The external and cut surfaces were uniformly purple-red with no focal lesions.

**GENITOURINARY TRACT:** The kidneys were similar in size, shape, and consistency and together weighed 325 grams. The capsules stripped

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with ease revealing brown-purple cortical surfaces. On the cut surface, the cortex and medulla were well demarcated. The renal papillae, calyces, and pelves were unremarkable. The ureters were of normal caliber and patent. The urinary bladder was empty. The lining mucosa was tan-purple-white. There were no focal lesions. The uterus with the attached cervix measured 3-1/2 inches by 2-1/2 inches by 1-3/8 inches. The serosal surfaces were smooth and glistening. The endometrial and endocervical canals were patent and empty. The uterine wall was unremarkable. The fallopian tubes and ovaries were unremarkable.

**GASTROINTESTINAL TRACT:** The esophagus was opened along its length and showed intact mucosa. The muscularis was intact. The stomach was opened along the greater curvature and was empty. The rugal pattern was maintained. The mucosa and muscularis were intact. The stomach was of relative small size. The small and large intestines were unremarkable. The appendix was present and was unremarkable.

**NECK:** The skin flap was reflected cephalad. The strap muscles were intact. The thyroid gland was of usual size, shape, and configuration. The hyoid bone was intact. The tongue was intact. The larynx and trachea did not show any foreign bodies. The lining mucosa was intact.

**HEAD:** The scalp was reflected by the usual mastoid to mastoid incision. There was no soft tissue hemorrhage. The skull bones were intact. The brain weighed 1300 grams. There was no epidural, subdural, or subarachnoid hemorrhage. The cranial nerves and vessels at the base of the brain were intact. The cerebellum and brain stem were serially sectioned. There were no focal lesions. The cerebral hemispheres were coronally sectioned. The ventricles were of relative normal size. The basal ganglia were unremarkable. The gray and white matter were well demarcated with no focal lesions. There was no intracerebral hemorrhage.

#### CULTURES

**BLOOD (aerobic and anaerobic) -**

Heart: No growth in five days.

Spinal Fluid: No growth in three days.

#### DIAGNOSES

1. Cardiomyopathy (heart weighed 500 grams).
2. Pulmonary edema and congestion.

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**REPORT OF ANALYSIS**

August 27, 1997

**TO:**

[REDACTED] M.D.  
Assistant Medical Examiner

**CASE#:**

[REDACTED]

Evidence submitted on 08/20/97

**RESULTS:**

Blood: Ethanol, Methanol, Acetone, Isopropanol- Not Detected.  
Marihuana Metabolite, Cocaine Metabolite,  
Barbiturate, Benzodiazepine, Phencyclidine,  
Propoxyphene, Amphetamine/Methamphetamine,  
Opiate, Methaqualone, Methadone- Not Detected.  
Standard Basic Drug Screen- Not Detected.

Unless otherwise requested, specimens will be discarded one year after date of receipt.

[REDACTED]

[REDACTED] B.S., M.T., ASCP  
Assistant Toxicologist

[REDACTED]

[REDACTED] Ph.D., DABFT  
Chief Toxicologist

[REDACTED]

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Medical Examiner's Initial

[REDACTED]

TOXICOLOGY DEPARTMENT

PHONE: [REDACTED]  
FAX: [REDACTED]

## TESTING FACILITY

Name: [REDACTED]

Address: [REDACTED]

Phone: [REDACTED]

Attn: [REDACTED]

Supervisor [REDACTED]

Test: [REDACTED]

Sample: [REDACTED]

Results: [REDACTED]

*Routine Aerobic & Anaerobic Blood*  
*(ID) Blood X 2 Cultures*  
*(Source) [REDACTED] Post Mortem*  
*NO GROWTH in 5 days*  
*X 2*

Tech's

Initials: \_\_\_\_\_

Normal or  
Therapeutic  
Range: \_\_\_\_\_

Date of

Analysis: \_\_\_\_\_

Please fax results*Doctor's Copy*

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TOXICOLOGY DEPARTMENT

PHONE: [REDACTED]

FAX: [REDACTED]

## TESTING FACILITY

Name: [REDACTED]

Address: [REDACTED]

Phone: [REDACTED]

Attn: [REDACTED]

Supervisor

Test:

Sample:

Results

Routine Culture  
(ID) SPINAL FLUID - Post Mortem  
(Source) Red Top and Swabs  
NO GROWTH in 3 days.

Tech's

Initials: \_\_\_\_\_

Normal or  
Therapeutic  
Range: \_\_\_\_\_Date of  
Analysis: \_\_\_\_\_Please fax results

DOCTOR'S COPY

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